	FO	R OHF	USE		

LL1

# 2004 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2004)

#### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number:	0032029		II. CERTII	FICATION BY AUTHORIZED FACILITY OFFICER
	Address: 9246 South Roberts Road Number	Hickory Hills City	60457 Zip Code	State of and cert are true	e examined the contents of the accompanying report to the Illinois, for the period from 01/01/04 to 12/31/04 tify to the best of my knowledge and belief that the said contents , accurate and complete statements in accordance with
	County:         Cook           Telephone Number:         (708) 598-404           IDPA ID Number:         36349938200			is based	ole instructions. Declaration of preparer (other than provider) don all information of which preparer has any knowledge. tional misrepresentation or falsification of any information ost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owner Type of Ownership:	s: <u>03/01/87</u>		Officer or	(Signed) (Date) (Type or Print Name)
	VOLUNTARY,NON-PROFIT Charitable Corp. Trust	X PROPRIETARY Individual Partnership	GOVERNMENTAL State County		(Title) (Signed)
	IRS Exemption Code	Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other	Other	Preparer	(Print Name and Title)  (Firm Name Frost, Ruttenberg & Rothblatt, P.C.
	In the event there are further questions al Name: Steve Lavenda	oout this report, please contact: Telephone Number: (847) 236 - 1	1111		& Address)         111 Pfingsten Road, Suite 300 Deerfield, IL 60015           (Telephone)         (847) 236-1111         Fax ‡ (847) 236-1155           MAIL TO: OFFICE OF HEALTH FINANCE         ILLINOIS DEPARTMENT OF PUBLIC AID           201 S. Grand Avenue East         Springfield, IL 62763-0001         Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numb	er Hickory Nurs	sing Pavilion				# 0032029 Report Period Beginning: 01/01/04 Ending: 12/31/04
	III. STATISTICA	L DATA				D. How many bed-hold days during this year were paid by Public Aid?	
	A. Licensure/o	certification level(s) of	f care; enter numbe	er of beds/bed days,			None (Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed	beds	N/A		
				_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							None
	Beds at				Licensed		
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of	Care	Report Period	Report Period		
				F			G. Do pages 3 & 4 include expenses for services or
1	34	Skilled (SNI	<del>(</del> 3)	34	12,444	1	investments not directly related to patient care?
2	_		atric (SNF/PED)		,	2	YES NO X
3	40	Intermediat	e (ICF)	40	14,640	3	
4		Intermediat	e/DD		Í	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered C	are (SC)			5	YES NO X
6		ICF/DD 16	or Less			6	<u> </u>
							I. On what date did you start providing long term care at this location?
7	74	TOTALS		74	27,084	7	Date started <u>03/01/87</u>
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	the entire report per					YES X Date 03/01/87 NO
	1	2	3	4	5		
	Level of Care	•	by Level of Care ar	nd Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid					YES X NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified 34 and days of care provided 921
8	SNF	4,412		921	5,333	8	
9	SNF/PED					9	Medicare Intermediary Mutual of Omaha
	ICF	15,540			15,540	10	
	ICF/DD					11	IV. ACCOUNTING BASIS
	SC					12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	19,952		921	20,873	14	Is your fiscal year identical to your tax year? YES NO
				•	•		
		cupancy. (Column 5,		otal licensed			Tax Year: 12/31/04 Fiscal Year: 12/31/04
	bed days or	n line 7, column 4.)	77.07%	_	SEE ACCOUNTAN	אדפי כב	* All facilities other than governmental must report on the accrual basis.  OMPILATION REPORT
<u> </u>					SEE ACCOUNTAL	115 ((	ani ilation refort

STATE OF ILLI	NOIS				Page 3
#	0032029	Report Period Beginning:	01/01/04	Ending:	12/31/04

	E W N A IDN I	*** * ** *	ъ	2	STATE OF ILL		n .n	ъ	04/04/04		Page 3	
	Facility Name & ID Number	Hickory Nursin			#	0032029	Report Period	Beginning:	01/01/04	Ending:	12/31/04	_
	V. COST CENTER EXPENSES (through	thout the report,	please round to osts Per Genera	the nearest dol	llar)	Dealogs	Daglaggified	Adinat	Adinated	EOD OIII	THEE ONLY	
	On speting Evyponess	Salary/Wage		Other	Total	Reclass- ification	Reclassified Total	Adjust-	Adjusted Total	ruk uhi	F USE ONLY	
	Operating Expenses	Salary/wage	Supplies 2					ments 7		0	10	
1	A. General Services Dietary	108,155	22,310	3 5,904	136,369	5	6 136,369	/	8 136,369	9	10	-
2	Food Purchase	100,133	98,527	3,904	98,527	(66,795)	31,732		31,732			2
3	Housekeeping	75,502	22,424		97,926	(00,793)	97,926		97,926			3
	Laundry	31,266	10,770		42,036		42,036		42,036			4
5	Heat and Other Utilities	31,200	10,770	60,474	60,474		60,474	754	61,228			5
6	Maintenance	24,918	13,118	35,142	73,178		73,178	(2,046)	71,132			6
7	Other (specify):*	24,916	13,110	33,142	73,176		73,176	370	370			7
	(1 3/											+
8	TOTAL General Services	239,841	167,149	101,520	508,510	(66,795)	441,715	(922)	440,793			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	646,258	21,232	3,502	670,992		670,992		670,992			10
10a	Therapy	17,365		698	18,063		18,063		18,063			10a
11	Activities	43,206	1,678	1,533	46,417		46,417		46,417			11
12	Social Services	67,515		2,418	69,933		69,933		69,933			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	774,344	22,910	13,651	810,905		810,905		810,905			16
	C. General Administration											
17	Administrative	55,762		146,400	202,162		202,162	(75,900)	126,262			17
18	Directors Fees											18
19	Professional Services			52,741	52,741		52,741	(524)	52,217			19
20	Dues, Fees, Subscriptions & Promotions			18,698	18,698		18,698	(11,781)	6,917			20
21	Clerical & General Office Expenses	23,621	29,014	25,759	78,394		78,394	8,079	86,473			21
22	Employee Benefits & Payroll Taxes			176,046	176,046	66,795	242,841		242,841			22
23	Inservice Training & Education				İ							23
24	Travel and Seminar			2,360	2,360		2,360	255	2,615			24
25	Other Admin. Staff Transportation			921	921		921	1,084	2,005			25
26	Insurance-Prop.Liab.Malpractice			63,497	63,497		63,497	1,170	64,667			26
27	Other (specify):*							14,598	14,598			27
28	TOTAL General Administration	79,383	29,014	486,422	594,819	66,795	661,614	(63,019)	598,595			28
• •	TOTAL Operating Expense	1.002.50	210.053	CO1 #C2	1.014.00		1.014.00	(62.0.11)	1.050.000			T
29	(sum of lines 8, 16 & 28)	1,093,568	219,073	601,593	1,914,234		1,914,234	(63,941)	1,850,293	T	1	29
	*Attach a schedule if more than one typ	e of cost is includ	led on this line.	or if the total ex	ceeds \$1000		SEE ACCOUNT.	ANTS' COMPIL	ATION REPOR	1		

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATED NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification. SEE ACCOUNTANTS' COMPILATION REPORT

**Hickory Nursing Pavilion** 

#0032029

**Report Period Beginning:** 

01/0<u>1</u>/04 Ending:

Page 4 12/31/04

# V. COST CENTER EXPENSES (continued)

			Cost Per General Ledger				Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			26,622	26,622		26,622	79,190	105,812			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,804	1,804		1,804	27,273	29,077			32
33	Real Estate Taxes			94,529	94,529		94,529	3,563	98,092			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)	0			34
35	Rent-Equipment & Vehicles							2,909	2,909			35
36	Other (specify):*							1,275	1,275			36
37	TOTAL Ownership			302,955	302,955		302,955	(65,790)	237,165			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,019	84,614	120,633		120,633		120,633			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		36,019	125,240	161,259		161,259		161,259	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,093,568	255,092	1,029,788	2,378,448		2,378,448	(129,731)	2,248,717			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**Report Period Beginning:** 

VI. ADJUSTMENT DETAIL

01/01/04

Page 5 **Ending:** 12/31/04

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

# 0032029

2 3 4 5 6 7 8 9 10 11 12 13 14	NON-ALLOWABLE EXPENSES  Day Care Other Care for Outpatients Governmental Sponsored Special Programs Non-Patient Meals Telephone, TV & Radio in Resident Rooms Rented Facility Space Sale of Supplies to Non-Patients Laundry for Non-Patients	Amount \$	Refe		1 2 3 4
2 3 4 5 6 7 8 9 10 11 12 13 14	Day Care Other Care for Outpatients Governmental Sponsored Special Programs Non-Patient Meals Telephone, TV & Radio in Resident Rooms Rented Facility Space Sale of Supplies to Non-Patients Laundry for Non-Patients		ence		3 4
2 3 4 5 6 7 8 9 10 11 12 13 14	Other Care for Outpatients Governmental Sponsored Special Programs Non-Patient Meals Telephone, TV & Radio in Resident Rooms Rented Facility Space Sale of Supplies to Non-Patients Laundry for Non-Patients	\$		\$	3 4
3 4 5 6 7 8 9 10 11 12 13 14	Governmental Sponsored Special Programs Non-Patient Meals Telephone, TV & Radio in Resident Rooms Rented Facility Space Sale of Supplies to Non-Patients Laundry for Non-Patients				3
4 5 6 7 8 9 10 11 12 13 14	Non-Patient Meals Telephone, TV & Radio in Resident Rooms Rented Facility Space Sale of Supplies to Non-Patients Laundry for Non-Patients				4
5 6 7 8 9 10 11 12 13 14	Telephone, TV & Radio in Resident Rooms Rented Facility Space Sale of Supplies to Non-Patients Laundry for Non-Patients				
6 7 8 9 10 11 12 13 14	Rented Facility Space Sale of Supplies to Non-Patients Laundry for Non-Patients				
7 8 9 10 11 12 13 14	Sale of Supplies to Non-Patients Laundry for Non-Patients				5
8 9 10 11 12 13 14	Laundry for Non-Patients				6
9 10 11 12 13 14					7
10 11 12 13 14					8
11 12 13 14	Non-Straightline Depreciation		658 30		9
12 13 14	Interest and Other Investment Income	(2,	,378) 32		10
13 1 14	Discounts, Allowances, Rebates & Refunds				11
14	Non-Working Officer's or Owner's Salary				12
	Sales Tax		02		13
15	Non-Care Related Interest				14
	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
	Non-Care Related Fees				17
18	Fines and Penalties	(1,	930) 21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,	556) 21		24
	Fund Raising, Advertising and Promotional	(6,	845) 20		25
	Income Taxes and Illinois Personal	(	723) 21		
	Property Replacement Tax				26
	Nurse Aide Training for Non-Employees				27
	Yellow Page Advertising	V 2	448) 20		28
	( )than Attach Cahadula	(9,	,729)		29
30	Other-Attach Schedule SUBTOTAL (A): (Sum of lines 1-29)	\$ 4.	049	s	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

			_	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(133,780)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (133,780)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (129,731)		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 1 2

3

4

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

	OHF USE ONL	Y				
48		49	50	51	52	

	NON-ALLOWABLE EXPENSES	Amount	Reference	_
1 2	Legal Fees Duplicate Payment	S (85)	19	l
3	Prior Period Legal	(1,375) (1,488)	19	t
4	Cope Dues	(1,488)	20	
5	Capitalized R & M	(5,881)	06	L
7	Accounting Fees (Bldg. Co.)	(900)	19	ŀ
8				ł
9				ł
10				t
11				t
12				T
13				
14				
15				L
16 17				F
18				t
19				t
20				t
21 22				Ť
22				
23				İ
24 25				I
26				ł
26 27				t
28				t
29				İ
30				Ι
31				İ
32				I
33				ļ
34 35		-		ł
36		<b>+</b>		ł
37				t
38		<b>†</b>		t
39				t
40				Ť
41				I
42				I
43 44				ļ
45				ł
46				t
47				t
48				t
49				t
50				İ
51				ı
52				I
53 54 55				
54				ł
				t
57				t
58				t
59				Τ
60				I
61				I
62				ļ
63				I
65				l
66		<b>†</b>		İ
66				ļ
68				İ
69				I
70 71				ļ
71 72				ļ
73		-		ł
73 74		l		t
75				t
76 77				İ
				I
78				Į
79		-		ł
80 81		-		Ī
82		<b>+</b>		ł
83		-		t
84				ı
85				Τ
86				ı
87				İ
88				
89 90		-		ł
90		<b>+</b>		ł
92		l		t
93		<b>†</b>		t
94				j
95				I
96				Į
97 98				ļ
		-		ł
00				
99 100				t

STATE OF ILLINOIS

Summary A 01/01/04 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: **Ending:** 

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D, 6	6E, 6F, 6G, 6H	I AND 6I										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.	.7)
1	Dietary													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			754									754	5
6	Maintenance	(5,881)		779	3,056								(2,046)	6
7	Other (specify):*				370								370	7
8	TOTAL General Services	(5,881)		1,533	3,426								(922)	8
	B. Health Care and Programs													
9	Medical Director												1	9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities												1	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(134,977)	59,077								(75,900)	17
18	Directors Fees													18
19	Professional Services	(2,360)	900	775		161							(524)	19
20	Fees, Subscriptions & Promotions	(11,781)											(11,781)	20
21	Clerical & General Office Expenses	(15,209)	134	23,154									8,079	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			255									255	24
25	Other Admin. Staff Transportation			1,084									1,084	25
26	Insurance-Prop.Liab.Malpractice		j	946		224							1,170	26
27	Other (specify):*			10,961	3,637								14,598	27
28	TOTAL General Administration	(29,350)	1,034	(97,802)	62,714	385							(63,019)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(35,231)	1,034	(96,269)	66,140	385							(63,941)	29

STATE OF ILLINOIS

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col	1.7)
30	Depreciation	41,658	35,397			2,135							79,190	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,378)	27,242	293		2,116							27,273	32
33	Real Estate Taxes					3,563							3,563	33
34	Rent-Facility & Grounds		(180,000)	8,480		(8,480)							(180,000)	34
35	Rent-Equipment & Vehicles			2,909									2,909	35
36	Other (specify):*		1,275										1,275	36
37	TOTAL Ownership	39,280	(116,086)	11,682		(666)							(65,790)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
	GRAND TOTAL COST				·									
45	(sum of lines 29, 37 & 44)	4,049	(115,052)	(84,587)	66,140	(281)							(129,731)	45

0032029

Report Period Beginning:

01/01/04 End

**Ending:** 

12/31/04

Page 6

### VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Effici below the fiallies of ALL (	wilers and ren	ateu organizations (parties) as denneu in the	ilisti uctions. Attach a	ii auditional schedu	ie ii liecessary.	
1		2			3	
OWNERS		RELATED NURSING HOM	ES	OTHER REL	ATED BUSINESS I	ENTITIES
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
11111						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			-		<u> </u>	Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	34	Rent Income	\$ 180,000	Hickory Healthcare Asociation	100.00%	\$	\$ (180,000)	1
2	V	32	Interest Income	191	<b>Hickory Healthcare Association</b>	100.00%		(191)	2
3	V		Accounting Fees		Hickory Healthcare Asociation	100.00%	900	900	3
4	V	32	Mortgage Interest		Hickory Healthcare Asociation	100.00%	27,433	27,433	4
- 5	V	30	Depreciation		Hickory Healthcare Asociation	100.00%	35,397	35,397	5
6	V	36	Amortization		Hickory Healthcare Asociation	100.00%	1,275	1,275	6
7	V	21	Replacement Tax		Hickory Healthcare Asociation	100.00%	134	134	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			s 180,191			\$ 65,139	\$ * (115,052)	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

eport Period Beginning:	01/01/04	En
eport reriou beginning.	01/01/04	EH

Page 6A nding: 12/31/04

VII.	REL	ATED	PARTI	ES (	(continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			0		0	Percent	Operating Cost	Adjustments for	
Sched	lule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V	5	UTILITIES	s	STAYCARE MANAGEMENT, LTD.	100.00%			15
16	V	6	REPAIRS AND MAINT.	-			779	779	16
17	V	10	REHABILITATION CONS.						17
18	V	17	ADMIN. SALNON OWNER				11,423	11,423	18
19	V	19	PROFESSIONAL FEES				775	775	19
20	V	20	DUES, SUBSCRIPTIONS						20
21	V	21	CLERICAL & GENERAL				23,154	23,154	21
22	V	24	SEMINARS				255	255	22
23	V	25	ADMIN. STAFF TRAVEL				1,084	1,084	23
24	V	26	INSURANCE				946	946	24
25	V		EMPLOYEE BENEFITS				10,961	10,961	25
26	V	30	DEPRECIATION						26
27	V		INTEREST				293	293	27
28	V		BUILDING RENT				8,480	8,480	28
29	V	35	EQUIPMENT RENTAL				2,909	2,909	29
30	V								30
31	V	17	MANAGEMENT FEES	146,400				(146,400)	
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39 T	<b>Total</b>			\$ 146,400			\$ 61,813	\$ * (84,587)	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE	OF	HI	IN	റ	1

Page 6B # 0032029 Facility Name & ID Number **Hickory Nursing Pavilion** Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued	I. RELA	TED	PARTIES	(continued)
---------------------------------	---------	-----	---------	-------------

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		İ	3		<u>c</u>	Percent	Operating Cost	Adjustments for	
Schedule	v	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ı
					ě	Ownership	Organization	Costs (7 minus 4)	
15 V	V	1	DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%		\$	15
16 V	V	6	MAINT. COMP NON-OWNER				3,056	3,056	16
17 \	V	7	EMP. BEN S. WEBSTER						17
18 V	V	7	EMP. BEN MAINT. NON-OWNER				370	370	18
19 \	V	17	ADMIN. COMP - H. WENGROW				49,231	49,231	19
20 \	V		ADMIN. COMP - J. WEBSTER				9,846	9,846	20
21 V	V		EMP. BEN H. WENGROW				3,036	3,036	
22 \ \	V	27	EMP. BEN J. WEBSTER				601	601	22
23 V	V								23
24 \	*								24
25 \ \	•								25
26 V	*								26
27 <b>\</b>	V								27
28 V	V								28
29 \	V								29
30 V	v .								30
31 V	V								31
32 V									32
33 V	*								33
34 \	•								34
33 1	V								35
36 V	V								36
3/	V								37
38 \	V								38
39 Total	l I			s			s 66,140	\$ * 66,140	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE	OF	HI	IN	റ	1

Page 6C # 0032029 Facility Name & ID Number **Hickory Nursing Pavilion** Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued	VII.	REL	ATED	PARTIES	(continued
---------------------------------	------	-----	------	---------	------------

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					-	Percent	Operating Cost	Adjustments for	
Schedu	ıle V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	DOUBLE YOU REALTY, LLC	100.00%	\$ 161		15
16	V	26	INSURANCE		DOUBLE YOU REALTY, LLC		224	224	16
17	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC		2,135	2,135	17
18	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		2,116	2,116	18
19	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		3,563	3,563	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	8,480	DOUBLE YOU REALTY, LLC			(8,480)	
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		-		-				38
39 To	otal			s 8,480			s 8,199	\$ * (281)	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF		С
----------	--	---

Page 6D # 0032029 Facility Name & ID Number **Hickory Nursing Pavilion** Report Period Beginning: 01/01/04 Ending: 12/31/04

VI	П	1	21	F1	. Δ	T	FD	١ (	P/	۸1	R'	Гī	F	Ç	(c	Λn	tin	nec	47

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		9			Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
Schedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)
15 V			e e		Ownership	e	\$ 15
16 V			J			3	16
17 V							17
18 V							18
19 V							19
20 V				,			20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 1							34
							35
30 V					1		36
37 V 38 V							37
<del> </del>							
39 Total			\$			<b>S</b>	\$ * 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

C.	r A '	TE	OF	TT :	ΙI	NI	1	c
	I A	н.	T)F			171		м

		STATE OF ILLINOI	S			I	Page 6E
Facility Name & ID Number	Hickory Nursing Pavilion	#	0032029	Report Period Beginning:	01/01/04	Ending:	12/31/04

# VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		0		5	Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
Senedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)	
15 V			e		Ownership	e		15
16 V			J			3		16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
J1 V								31
32 ,								32
7								34
34 V 35 V	-							35
36 V								36
37 V								37
38 V			1					38
					ı			
39 Total			[\$			\$	\$ *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE	OF	HI	IN	റ	1

Page 6G # 0032029 Facility Name & ID Number **Hickory Nursing Pavilion** Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)
----------------------------------

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		0		5	Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
Senedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)	
15 V			e		Ownership	e		15
16 V			J			3		16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
J1 V								31
32 ,								32
7								34
34 V 35 V	-							35
36 V								36
37 V								37
38 V			1					38
					ı			
39 Total			[\$			\$	\$ *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE	OF I	LLIN	MIS

		STATE OF ILLINOI				I	Page 6F	
Facility Name & ID Number	Hickory Nursing Pavilion	#	0032029	Report Period Beginning:	01/01/04	Ending:	12/31/04	

# VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wit	h related o	rganizations?	This includes rea	ıt,
	management fees, purchase of supplies, and so forth.	YES		NO	

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		0		5	Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
Senedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)	
15 V			e		Ownership	e		15
16 V			J			3		16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
J1 V								31
32 ,								32
7								34
34 V 35 V	-							35
36 V								36
37 V								37
38 V			1					38
					ı			
39 Total			[\$			\$	\$ *	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE (	)F IL	LIN(	ЭIS
---------	-------	------	-----

		STATE OF ILLINOI				F	Page 6H	
Facility Name & ID Number	Hickory Nursing Pavilion	#	0032029	Report Period Beginning:	01/01/04	Ending:	12/31/04	

VII. RELATED PARTIES (continued)	
----------------------------------	--

B.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizat	ions?	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		9			Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
Schedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)
15 V			e e		Ownership	e	\$ 15
16 V			J			3	16
17 V							17
18 V							18
19 V							19
20 V				,			20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 1							34
							35
30 V					1		36
37 V 38 V							37
<del> </del>							
39 Total			\$			<b>S</b>	\$ * 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

S

		STATE OF ILLINO				I	Page 6I	
Facility Name & ID Number	Hickory Nursing Pavilion	#	0032029	Report Period Beginning:	01/01/04	Ending:	12/31/04	

# VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		9			Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
Schedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)
15 V			e e		Ownership	e	\$ 15
16 V			J			3	16
17 V							17
18 V							18
19 V							19
20 V				,			20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 1							34
							35
30 V					1		36
37 V 38 V							37
<del> </del>							
39 Total			\$			<b>S</b>	\$ * 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

## Facility Name & ID Number

**Hickory Nursing Pavilion** 

0032029

**Report Period Beginning:** 

01/01/04

**Ending:** 

12/31/04

# VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hou	rs Per Work				
					Compensation	Week Devo	oted to this	Compensation Included		Schedule V.	
					Received	Facility and % of Total in Costs for this		Line &			
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Jeff Webster	Owner	Administration	14.19%	See Attached	4.00	6.15%	Salary-Staycar	\$ 9,846	17-7	1
2	Howard Wengrow	Owner	Administration	14.19%	See Attached	20.00	30.77%	Salary-Staycar	e 49,231	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 59,077		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS	Page 8
-------------------	--------

25

	Facility Name	e & ID Number	Hickory Nurs	sing Pavilion		# 0032029	Report Period Beginning:	01/01/04	Ending:	12/31/04	
		CATION OF INDIRE						ated Organization			
				which were derived fron		al office	Street Addre			_	
	or pare	ent organization costs	? (See instruct	tions.) YES	NO	X	City / State /	Zip Code			
							Phone Numb		)		
	B. Show th	he allocation of costs	below. If nece	essary, please attach work	sheets.		Fax Number	(	)		
		T			T		1	1		T	
	1	2		3	4	5	6	7	8	9	
	Schedule V			Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line			(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item		Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1							\$	\$		\$	1
2											2
3											3
4											4
5											5
3 4 5 6 7											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21 22											21
22									1		22
23											23

**Hickory Nursing Pavilion** 

# 0032029 Report Period Beginning:

01/01/04

Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES X

Name of Related Organization Street Address

STAYCARE MANAGEMENT, LTD. 3737 W ARTHUR AVENUE

City / State / Zip Code Phone Number

LINCOLNWOOD, IL 60712 ( (847) 679-2121

B. Show the allocation of costs below. If necessary, please attach worksheets.

Fax Number

( (847) 679-2122

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	179,695	5	\$ 6,487	\$	47,577	\$ 754	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	179,695	5	6,706		47,577	779	2
3	10	REHABILITATION CONS.	PATIENT DAYS	179,695	5			47,577		3
4	17	ADMIN. SALNON OWNER	PATIENT DAYS	179,695	5	98,340	98,340	47,577	11,423	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	179,695	5	6,675		47,577	775	5
6	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	179,695	5			47,577		6
7	21	CLERICAL & GENERAL	PATIENT DAYS	179,695	5	199,330	166,344	47,577	23,154	7
8	24	SEMINARS	PATIENT DAYS	179,695	5	2,196		47,577	255	8
9	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	179,695	5	9,336		47,577	1,084	9
10	26	INSURANCE	PATIENT DAYS	179,695	5	8,145		47,577	946	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	179,695	5	94,366		47,577	10,961	11
12	30	DEPRECIATION	PATIENT DAYS	179,695	5			47,577		12
13	32	INTEREST	PATIENT DAYS	179,695	5	2,522		47,577	293	13
14	34	BUILDING RENT	PATIENT DAYS	179,695	5	73,000		47,577	8,480	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	179,695	5	25,045		47,577	2,909	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 532,148	\$ 264,684		\$ 61,813	25

# 0032029 Report Period Beginning: Facility Name & ID Number Hickory Nursing Pavilion 01/01/04 Ending: 12/31/04

### VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	STAYCARE MANAGEMENT, LTD.
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	3737 W ARTHUR AVENUE
or parent organization costs? (See instructions.)  YES X  NO	City / State / Zip Code	LINCOLNWOOD, IL 60712
<del></del>	Phone Number	( (847) 679-2121
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( (847) 679-2122

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1	DIET, COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	10,941	10,941		\$	1
2	6	MAINT. COMP NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	5	3,056	2
3	7	EMP. BEN S. WEBSTER	AVG. HOURS WORKED	35	1	1,410				3
4	7	EMP. BEN MAINT. NON-OWN	AVG. HOURS WORKED	40	5	3,183		5	370	4
5	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	160,000	160,000	20	49,231	5
6	17		AVG. HOURS WORKED		5	160,000	160,000	4	9,846	6
7		EMP. BEN H. WENGROW	AVG. HOURS WORKED		5	9,866		20	3,036	7
8	27	EMP. BEN J. WEBSTER	AVG. HOURS WORKED	65	5	9,761		4	601	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 381,471	\$ 357,251		\$ 66,140	25

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/04 Ending: 12/31/04

### VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	DOUBLE YOU REALTY, LLC
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	3737 W. ARTHUR AVENUE
or parent organization costs? (See instructions.)  YES X  NO	City / State / Zip Code	LINCOLNWOOD, IL 60712
	Phone Number	( (847) 679-2121
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	(847) 679-2122

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	179,695	5	\$ 1,385	\$	20,873	\$ 161	1
2	26	INSURANCE	PATIENT DAYS	179,695	5	1,930		20,873	224	2
3	30	DEPRECIATION	PATIENT DAYS	179,695	5	18,377		20,873	2,135	3
4		INTEREST EXPENSE	PATIENT DAYS	179,695	5	18,213		20,873	2,116	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	179,695	5	30,672		20,873	3,563	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 70,577	\$		\$ 8,199	25

STATE OF ILLINOIS	Page 8D

				STATE OF ILL	LINUIS			Page 8D	,
Facility Name	& ID Number Hickory	Nursing Pavilion		# 0032029 R	eport Period Beginning:	01/01/04	Ending:	12/31/04	
VIII. ALLOC	ATION OF INDIRECT COS	STS							
			n e .	1 00		ated Organization			
	re any costs included in this i nt organization costs? (See in	report which were derived from structions.) YES	allocations of centr	al office	Street Addro City / State /			_	
or pare	iit organization costs: (See iii	istructions.)	NO		Phone Numb			_	
B. Show th	ne allocation of costs below. I	f necessary, please attach work	sheets.		Fax Number		)		
1	2	3	4	5	6	7	8	9	$\Box$
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
		1 1		8	\$	\$		\$	1
									2
									3
									4
									5
									7
									8
									9
									1
									1
									12
									1.
									14
									15
									1'
									18
									19
									20
									2
							-		22
									23
									24
TOTALS					\$	\$		\$	25

STATE OF ILLINOIS	Page 8	8E

				STATE OF IEI	Elitois			ruge on	
Facility Name &	ID Number Hickory	Nursing Pavilion		# 0032029 R	Report Period Beginning:	01/01/04	Ending:	12/31/04	
VIII. ALLOCAT	TION OF INDIRECT COS	TS							
					Name of Rel	ated Organization			
		eport which were derived from		al office	Street Addr				
or parent o	organization costs? (See ins	structions.) YES	NO		City / State	Zip Code			
<b>D</b> (1)			•		Phone Num		)		
B. Show the a	illocation of costs below. If	f necessary, please attach works	sheets.		Fax Number	r <u>(</u>	)		
1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1		1			\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19							ļ		19
20 21									20
22							<del> </del>		22
23									23
24									24
25 TOTALS					s	s		s	25
					TS! COMDII ATION DE	1*		*	120

STATE OF ILLINOIS	Page 8F
-------------------	---------

	Facility Name	e & ID Number Hickory N	Nursing Pavilion		# 0032029 R	Report Period Beginning:	01/01/04	Ending:	12/31/04	
	VIII. ALLOC	CATION OF INDIRECT COST	S							
							ated Organization			
		ere any costs included in this rep			al office	Street Addre				
	or par	ent organization costs? (See inst	ructions.) YES	NO		City / State /	Zip Code		_	
	D CI					Phone Numb		)		
	B. Show t	the allocation of costs below. If i	necessary, please attach work	sheets.		Fax Number	<u>(</u>	)	<del></del>	
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e., Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			1			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7 8										7 8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18 19
19 20										20
21										21
22										22
23	1									23
24										24
	TOTALS					\$	\$		\$	25

STATE OF ILLINOIS	Page 8G

					STATE OF IL	LINOIS			Page 8G	3
Fac	cility Name & ID N	umber Hickory	Nursing Pavilion		# 0032029 F	Report Period Beginning:	01/01/04	Ending:	12/31/04	_
VII	II. ALLOCATION	OF INDIRECT COS	ΓS							
		or institutor cos				Name of Rel	ated Organization			
			eport which were derived from		r <u>al offi</u> ce	Street Addr				
	or parent orga	nization costs? (See ins	structions.) YES	NO		City / State /	Zip Code			
	D Charritha allaas	4:£4- b-l 14		-h4		Phone Number		<u>)</u>		
	b. Show the alloca	ition of costs below. If	necessary, please attach work	sneets.		rax Number	<u>(</u>	)		
	1	2	3	4	5	6	7	8	9	
Sc	chedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
R	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			- <b>4</b>			\$	\$		\$	-
2										
3										
4										
5										
6										_
7										_
8										_
0										_
1										-
2										-
3										-
4										
5										
6										
7										
8										_
9										_
0										_
22						+				_
23							+			_
24						+				-
	OTALS					e	s		s	-
23 110	IALS					Φ	Φ		Φ	_

STATE OF ILLINOIS	Page 8H

					STATE OF ILL	LINUIS			Page 8H	
	Facility Name	e & ID Number Hickory Nu	rsing Pavilion		# 0032029 R	Report Period Beginning:	01/01/04	Ending:	12/31/04	
	VIII. ALLOC	CATION OF INDIRECT COSTS				Name of Rel	ated Organization			
	A. Are the	ere any costs included in this repor	rt which were derived from	allocations of centr	al office	Street Addre				-
	or pare	ent organization costs? (See instru	ctions.) YES	NO		City / State /	Zip Code			
	<b></b>					Phone Numb		)	<u> </u>	
	B. Show t	he allocation of costs below. If neo	cessary, please attach work	sheets.		Fax Number	<u>(</u>	)	<del></del>	
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
9										8
10										10
11										11
12										12
13			+							13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

STATE OF ILLINOIS	Page :	8	ĺ
-------------------	--------	---	---

	Facility Name	e & ID Number Hickory Nur	rsing Pavilion		# 0032029	Report Period Beginning:	01/01/04	Ending:	12/31/04	
	VIII. ALLOC	CATION OF INDIRECT COSTS				Name of Rel	ated Organization			
	A. Are the	ere any costs included in this repor	t which were derived fron	n allocations of centr	al office	Street Addr				
		ent organization costs? (See instruc				City / State /			-	
		g	,			Phone Numl	ber (	)	•	
	B. Show th	he allocation of costs below. If nec	essary, please attach work	ksheets.		Fax Number	· <u>(</u>	)		
	1	2	3	4	5	6	7	8	9	T
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	-	Item		Total Units	Allocated Among		in Column 6	Units	(col.8/col.4)x col.6	
1	Reference	Item	Square Feet)	Total Ullits	Allocated Alliong	Allocated	e in Column o	Units	(CO1.6/CO1.4)X CO1.0	1
2						<b>D</b>	J		D .	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13 14
14										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

		STATE OF ILLINOIS		Page 9
Facility Name & ID Number	Hickory Nursing Pavilion	# 0032029 Report Period Beginning: 01/0	1/04 Ending:	12/31/04

### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

_	1	2		3	4	5	6	7	8	9	10	
											Reporting	
					Monthly				Maturity	Interest	Period	
	Name of Lender	Relate		Purpose of Loan	Payment	Date of		ınt of Note	Date	Rate	Interest	
		YES	NO		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related											
	Long-Term											
1	Alloc. From Hickory HC Assoc	iates	X	Mortgage MB Financial			\$	\$ 550,212			\$ 27,433	
2												2
3	Alloc. From Double You		X	Mortgage MB Financial							2,116	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Alloc. From Stay Care		X								293	6
7	<b>Due on Insurance</b>		X	Insurance				56,794			1,804	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						e e	\$ 607,006			\$ 31,646	9
,	B. Non-Facility Related*	+					<u> </u>	\$ 007,000			31,040	
10	B. Non-Facility Related									T		10
11												11
12												12
	Sac Supplemental Schodule									+	(2.560)	
13	See Supplemental Schedule										(2,569	13
14	TOTAL Non-Facility Related						\$	s			\$ (2,569)	) 14
15	TOTALS (line 9+line14)						\$	\$ 607,006			\$ 29,077	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	N/A	Line #	
--	----	-----	--------	--

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Hickory Nursing Pavilion STATE OF ILLINOIS Page 9 - SUPPLEMENTAL # 0032029 Report Period Beginning: 01/01/04 Ending: 12/31/04

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

2 10 Reporting Monthly Maturity Interest Period Name of Lender Related\*\* **Purpose of Loan Payment Amount of Note** Date Rate Interest Date of YES NO Required Original Note Balance (4 Digits) Expense A. Directly Facility Related Long-Term 1 2 2 3 3 4 4 5 5 6 6 7 TOTAL Long-Term 7 **Working Capital** 8 9 9 10 10 11 11 12 12 13 13 14 14 TOTAL Working Capital B. Non-Facility Related\* 15 Interest Income 15 (2,378)16 16 Interest Income Bldg. Co. (191)17 17 18 18 19 19 20 TOTAL Non-Facility Related (2,569) 20

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
# 0032029 Report Period Beginning: 01/01/04 Ending: 12/31/04

Facility Name & ID Number Hickory Nursing Pavilion

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

**B.** Real Estate Taxes

B. Real Estate Taxes						_
1 Bed Estate Temperatured on 2002 month	<i>Important</i> , please see the next worksheet, bill must accompany the cost report.	, "RE_Tax". The real	estate tax statement and		02.122	+
1. Real Estate Tax accrual used on 2003 report.	biii mast accompany the cost report.			3	92,123	1
2. Real Estate Taxes paid during the year: (Indicate the t	ux year to which this payment applies. If payment cov	ers more than one year, de	tail below.)	s	95,510	2
3. Under or (over) accrual (line 2 minus line 1).				s	3,387	3
4. Real Estate Tax accrual used for 2004 report. (Detail	and explain your calculation of this accrual on the line	es below.)		s	94,705	4
5. Direct costs of an appeal of tax assessments which ha (Describe appeal cost below. Attach copie	1	1 0		\$		5
Subtract a refund of real estate taxes. You must offse classified as a real estate tax cost plus one-half of any  TOTAL REFUND \$ For	, 11	eal estate tax appeal	board's decision.)	s		6
7. Real Estate Tax expense reported on Schedule V, line	<u> </u>			\$	98,092	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year: 1999	90,982		FOR OHF USE ONLY			Т
2000 2001	92,790 9 94,953 10	13	FROM R. E. TAX STATEMENT FOR	R 2003	\$	13
2002 2003	89,440 11 91,947 12	14	PLUS APPEAL COST FROM LINE	5	\$	14
2004 Accrual \$91,947 x 1.03 = \$94,705						
Alloc. From Double You \$3,563		15	LESS REFUND FROM LINE 6		\$	15
		16	AMOUNT TO USE FOR RATE CAL	CULATION	<b>s</b>	16

#### NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
  application for real estate tax exemption unless the building is rented from a for-profit entity.
  This denial must be no more than four years old at the time the cost report is filed.

#### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

### 2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME Hickory Nursin	g Pavilion			COUNTY	Cook				
FAC	ILITY IDPH LICENSE NUMBER	0032029		_						
CON	TACT PERSON REGARDING TH	HS REPORT Steve Lav	venda	="						
TEL	EPHONE (847)236-1111		FAX#:	(847)236-1	155					
A.	Summary of Real Estate Tax Co	st	_							
	Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.									
	(A)	(B)			(C)		(D)			
	Tax Index Number	Property Desc	ription_		Total Tax		Tax Applicable to Nursing Home			
1.	23-02-420-008-0000	Long Term Care Pro	perty	\$	38,661.09	\$	38,661.09			
2.	23-02-420-016-0000	Long Term Care Pro	perty	\$	38,642.51	\$	38,642.51			
3.	23-01-302-021-0000	Long Term Care Pro	perty	\$_	7,165.83	\$_	7,165.83			
4.	23-02-420-015-0000	Long Term Care Pro	perty	\$	4,870.72	\$_	4,870.72			
5.	23-02-420-007-0000	Long Term Care Pro	perty	\$_	2,606.44	\$_	2,606.44			
6.	10-35-329-014-0000	Alloc.From Double	You	\$_	30,562.00	\$_	3,562.80			
7.				\$_		\$_				
8.				_ \$_						
9.				_ \$_		_ \$_				
10.				_ \$_		_ \$_				
			TOTALS	\$_	122,508.59	s_	95,509.39			
B.	Real Estate Tax Cost Allocations	<u>s</u>								
	Does any portion of the tax bill ap used for nursing home services?	ply to more than one nur  X YES	sing home,	vacant prope NO	rty, or propert	ty which is n	ot directly			
	If YES, attach an explanation & a (Generally the real estate tax cost						ome.			

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

C. Tax Bills

Page 10A

#### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filled until this statement and the corresponding real estate tax bills are filled. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

# 2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Hickory Nursing P	avilion		COUNTY	Cook	
FAC	ILITY IDPH LICE	ENSE NUMBER	0032029				
CON	TACT PERSON R	REGARDING THIS	REPORT Steve Lave	nda			
TELI	EPHONE (847)23	36-1111		FAX#: (84	47)236-1155		
A.	· ·	al Estate Tax Cost					
71.							
			state tax assessed for 2 e nursing home in Colu				
	home property wl	hich is vacant, rented	I to other organizations	, or used for pu	urposes other than long		
	entered in Colum	n D. Do not include	cost for any period oth	ner than calend	lar year 2000.		
	(A)	)	(B)		(C)		(D)
							Tax Applicable to
	Tax Index	Number	Property Descri	<u>ption</u>	Total Tax		Nursing Home
1.					\$	\$	
2.		<u> </u>			\$	_ \$_	
3.		<u> </u>			\$	\$_	
4.					\$	\$_	
5.					\$	_ \$_	
6.					\$		
7.					\$		
8.					\$		
9. 10.					\$		
10.		<del></del> -				-	
				TOTALS	s	\$	
					-		
B.	Real Estate Tax	Cost Allocations					
			to more than one nursi			y which is r	ot directly
	used for nursing h	nome services?	YES	NO	,		
			edule which shows the				ome.
	(Generally the rea	al estate tax cost mus	st be allocated to the nu	irsing home ba	ised upon sq. ft. of space	ce used.)	
C	Toy Bills						

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which

is normally paid during 2001.

Page 10B

STAT	STATE OF ILLINOIS					
y Name & ID Number Hickory Nursing Pavilion	#	0032029	Report Period Beginning:	01/01/04	<b>Ending:</b>	12/31/04
ILDING AND GENERAL INFORMATION:						

Facil	ity Name & ID Number Hickory	y Nursing Pavilion		# 0032029	Report Period Beginning:	01/01/04 Ending:	12/31/04
X. B	UILDING AND GENERAL INFO	ORMATION:					
A.	Square Feet:	16,200 B. General Construction	Type: Exterior	Brick	Frame Brick	Number of Stories	1
C.	Does the Operating Entity?	(a) Own the Facility	X (b) Rent from	a Related Organization	ı <b>.</b>	(c) Rent from Completely Unrel Organization.	lated
	(Facilities checking (a) or (b) n	must complete Schedule XI. Those ched	cking (c) may complete Schedu	le XI or Schedule XII-A	A. See instructions.)	· · <b>s</b>	
D.	Does the Operating Entity?	X (a) Own the Equipment	X (b) Rent equip	oment from a Related O	rganization.	X (c) Rent equipment from Comp Unrelated Organization.	letely
	(Facilities checking (a) or (b) n	must complete Schedule XI-C. Those c	hecking (c) may complete Sche	dule XI-C or Schedule	XII-B. See instructions.)	, and the second	
E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)  List entity name, type of business, square footage, and number of beds/units available (where applicable).  None							
	D 41: 4 4 6 4				NTC NTC	No	
F.	If so, please complete the follow	ny organization or pre-operating costs wing:	which are being amortized?		YES	NO	
1.	. Total Amount Incurred:			2. Number of Years O	ver Which it is Being Amor	rtized:	
3	. Current Period Amortization:			4. Dates Incurred:			
		Nature of Costs: (Attach a complete scheo	dule detailing the total amount	of organization and pro	e-operating costs.)		
XI. C	OWNERSHIP COSTS:						
		1	2	3	4		
	A. Land.	Use	Square Feet	Year Acquired	Cost		
		1 Facility	16,200	1990		1 2	
		2 Alloc. From Double 3 TOTALS	e You 16,200	2003	5,808 \$ 79,808	$\frac{2}{3}$	
		3 IUIALS	10,200		79,808	3	

	D. Dulluli	ng Depreciation-Including Fixed Equ	uipinent. (See inst	uctions.) Roun	u an numbers to nea	rest dollar.		-		9	
	1	FOR OHF USE ONLY	Year		4		6 Life	C4	8	Accumulated	
	D 1 4	FOR OHF USE ONLY		Year	<b>6</b> 4	Current Book		Straight Line			
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impro	vement Type**									
9	Various	• •		1987	22,801		20	1,140	1,140	16,714	9
	Various			1988	50,319		20	2,516	2,516	35,666	10
	Various			1989	7,409		20	370	370	4,772	11
	Various			1990	38,661		20	1,934	(1,934)	25,239	12
13	Various			1991	6,422		20	321	321	3,912	13
14	Various			1993	30,582		20	1,530	1,530	16,281	14
15	Various			1994	13,592		20	680	680	6,824	15
16	Various			1995	102,781		20	5,139	5,139	47,369	16
17	Various			1996	139,610		20	6,980	6,980	60,466	17
18	Various			1997	54,749		20	2,739	2,739	20,531	18
19	Various			1998	53,522		20	2,676	2,676	17,862	19
20	Various			1999	18,879		20	944	944	5,136	20
21	Various			2000	6,891		20	345	345	1,379	21
22								-		_	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42				İ				42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								50
57								57
58 59								58 59
								60
60								61
62				1			-	62
63				1			-	63
64				1			-	64
65				1			-	65
66				-				66
		1,115,000	35,397	-	55,750	20,353	683,170	67
67 Related Building Company (Pages 12-BLDG & 12A-BLDG) 68 Related Party Allocations (Pages 12-REP & 12A-REP)		58,088	1,423	-	1,552	129	2,988	68
69 Financial Statement Depreciation		50,000	26,622		1,552	(26,622)	2,700	69
70 TOTAL (lines 4 thru 69)		\$ 1,719,306	\$ 63,442		\$ 84,616	\$ 17,306	\$ 948,309	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		s 1,719,306	\$ 63,442		<b>84,616</b>	\$ 21,174	\$ 948,309	1
2 Schematic Design	2001	5,835		20	292	292	1,143	2
3 Lights	2001	1,306		20	65	65	207	3
4 Wiring	2001	5,775		20	289	289	890	4
5 Wiring Outlets	2002	14,779		20	1,478	1,478	4,434	5
6 Drywall-Office	2002	2,650		20	265	265	707	6
7 Call Cord	2002	564		20	56	56	127	7
8 Motor	2002	1,854		20	185	185	541	8
9 Relay Switch	2002	537		20	54	54	139	9
10 Coupler	2002	754		20	75	75	170	10
11 Heater	2002	3,539		20	354	354	855	11
12 Tuckpointing	2003	3,800		20	380	380	570	12
13 Outside Fence	2003	2,230		20	112	112	204	13
14 Outside Fence	2003	600		20	30	30	48	14
15 Outside Fence	2003	1,200		20	60	60	90	15
16 Electrical Repair	2003	735		20	37	37	49	16
17 Fire Rated Door	2003	655		20	33	33	41	17
18 Fire Rated Door	2003	533		20	27	27	33	18
19 Outside Fence	2003	730		20	37	37	46	19
20 Outside Fence	2003	900		20	45	45	56	20
21 Signage	2003	2,012		20	101	101	126	21
22 Flooring	2003	699		20	35	35	41	22
Nurses Station Remodeling	2003	8,482		20	424	424	495	23
24 Telephone Installation	2003	515		20	26	26	30	24
25 Wallcovering	2003	1,001		20	50	50	58	25
26 Wall Covering, Paint, Flooring	2003	43,996		20	2,200	2,200	2,750	26
27 Motor For Furnace	2004	818		20	3	3	3	27
28 Fire Door Frame	2004	758		20	3	3	3	28
29 Door	2004	1,156		20	53	53	53	29
30 Thermostat And Temp. Sensors	2004	628		20	13	13	13	30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12C 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

I I	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15 16
17								17
18								18
19								19
20							+	20
21				1			<u> </u>	21
22								22
23								23
24				İ				24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12D 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-including Fixed Equipment	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		<b>\$</b> 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14 15
16				1				16
17								17
18								18
19				1				19
20								20
21								21
22				İ				22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		1 020 2 1	0.4/2		01.262	25.05	0.0000	33
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12E 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12D, Carried Forward		s 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14 15
16								16
17				1				17
18								18
19							+	19
20								20
21								21
22				İ				22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		1 020 2 17	(2.1/2		01.262	25.05	0.000	33
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12F 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

I I	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12E, Carried Forward		s 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14 15
16								16
17								17
18								18
19				-			-	19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12G 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14 15
16				1				16
17								17
18							+	18
19				1			<u> </u>	19
20								20
21								21
22				İ				22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		0 1 020 245	. (2.442		01 200	25.054	0(2.221	33
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12H 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion
XI. OWNERSHIP COSTS (continued) # 0032029 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Includin	g Fixed Equipment.	(See instructions.) Round a	all numbers to nearest dollar.

B. Building Depreciation-including Fixed Equipment. (See inst	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
12								11
13								13
14				1				14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26 27
27 28								28
28 29	-			<del> </del>				29
30				<b> </b>				30
31				1				31
32				1				32
33	<u> </u>			<del> </del>				33
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12I 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Including Fixed Equipment. (See insti	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12H, Carried Forward		s 1,828,347	\$ 63,442		<b>\$</b> 91,398	\$ 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28 29								28 29
30	<u> </u>		+					30
31	<del>                                     </del>		+	-		<b> </b>		31
32								32
33								33
34 TOTAL (lines 1 thru 33)		s 1,828,347	\$ 63,442		\$ 91,398	s 27,956	s 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12J 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Including Fixed Equipment. (See I	3	4	5	6	7	8	9	$\Box$
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12I, Carried Forward		s 1,828,347	\$ 63,442		\$ 91,398	s 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14 15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29				ļ				29
30				ļ				30
31								31
32 33				ļ				32
	_	0 1 020 247	6 63 443		6 01 200	0 27.056	\$ 962,231	33 34
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12K 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion

XI. OWNERSHIP COSTS (continued)

R Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to # 0032029 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Including Fixed Equipm	ent. (See instructions.) Round	d all numbers to near						
1	3	4	5	6	7	8	9,,,	
	Year	<b>6</b> .	Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12J, Carried Forward		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		- 40000:-			04.00			33
34 TOTAL (lines 1 thru 33)		\$ 1,828,347	\$ 63,442		\$ 91,398	\$ 27,956	\$ 962,231	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12-BLDG 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4			1990		\$ 1,115,000	\$ 35,397		\$ 55,750	s 20,353	\$ 683,170	4
5											5
6											6
7											7
8											8
	Impro	vement Type**								•	
9	•	••							I		9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26 27											26 27
											28
28 29											28
30											30
31											31
32				<del>                                     </del>						1	32
33											33
34											34
35											35
				i	1	1		1	1	1	

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A-BLDG 12/31/04 STATE OF ILLINOIS Facility Name & ID Number Hickory Nursing Pavilion # 0032

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

l I I I I I I I I I I I I I I I I I I I	3	4	5	6	7	8	9	$\top$
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		S	s		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52 53								52 53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65		-						65
66								66
67								67
68								68
69			25.205			20.252	02.150	69
70 TOTAL (lines 4 thru 69)		\$ 1,115,000	\$ 35,397		\$ 55,750	\$ 20,353	\$ 683,170	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12-REP 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

	1	ng Depreciation-Including Fixed Equ	1 2	3	4	5	6	7	8	9	
	1	FOR OHF USE ONLY	Year	Year	7	Current Book	Life	Straight Line	0	Accumulated	
	Beds*	FOR OHF USE ONL!	Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
<b>L</b> .		D II W					III Tears				+ .
4	Allocated Fi	om Double You	2003	2003	\$ 55,516	\$ 1,423		\$ 1,424	\$ 1	\$ 2,788	4
5											5
6											6
7											7
8											8
	Impr	ovement Type**									
9	Aloc. From		2003	2003	2,572	-	20	128	128	200	9
10					, and the second						10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36							İ				36

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A-REP 12/31/04 Facility Name & ID Number Hickory Nursing Pavilion # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0032029 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Including Fixed Equipment. (See ins	3	4	5	6	7	8	9	
ī	Year	7	Current Book	Life	Straight Line	0	Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	l l
37		S	e	III I Cars	e	e Aujustinents	© Bepreciation	37
38		3	J		J	3	3	38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65				t				65
66								66
67				İ				67
68				t				68
69				İ				69
70 TOTAL (lines 4 thru 69)		s 58,088	\$ 1,423		\$ 1,552	s 129	\$ 2,988	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STATE	OF	ш	JN	OIS

Page 13 Facility Name & ID Number **Hickory Nursing Pavilion** 0032029 **Report Period Beginning:** 01/01/04 12/31/04 **Ending:** 

## XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	ĺ	Current Book Straight Line		4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 124,356	\$ 711	\$ 12,988	\$ 12,277	10	\$ 67,597	71
72	Current Year Purchases	13,533		775	775	10	775	72
73	Fully Depreciated Assets	210,548				10	210,548	73
74								74
75	TOTALS	\$ 348,437	\$ 711	\$ 13,763	\$ 13,052		\$ 278,920	75

D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76		Alloc. Stay Care	2003	\$ 3,252	\$	\$ 650	\$ 650	5	<b>\$</b> 976	76
77										77
78										78
79										79
80	TOTALS			\$ 3,252	\$	\$ 650	\$ 650		\$ 976	80

F Summary of Care Polated Assets

J	L. Summary of Care-Related Assets	I	<u> </u>			
		Reference	Amount		Ī	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,259,844	81		
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,153	82	]	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,811	83	**	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 41,658	84		
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,242,127	85	1	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

This must agree with Schedule V line 30, column 8.

Facil	ity Name & II	) Number	Hickory Nursing Pav	ilion		STATE OF ILLINOIS # 0032029		t Period Beginning:	01/01/04	Ending:	Page 14 12/31/04
	1. Name of P 2. Does the fa	nd Fixed Equi Party Holding	ipment (See instructions.) Lease: N/A y real estate taxes in addi	tion to rental a	mount shown below on		]NO				
		1 Year Constructe	2 Number d of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*				
3	Original Building: Additions			s				3 Beginnin 4 Ending	ve dates of curren	<u> </u>	
7 TOTAL \$ **  8. List separately any amortization of lease expense included on page 4, line 34.								7 rental a	agreement:	·	
	This amou	int was calcul igth of the lea	ated by dividing the total	amount to be a		*		12. 13. 14.	/2005 /2006 /2007	Annual Re	
	15. Îs Movab 16. Rental A	ole equipment mount for mo	ransportation and Fixed rental included in buildin wable equipment:		e instructions.) Description:		NO e detailing the brea	ıkdown of movable equi	pment)		
	C. Vehicle Re	ntal (See insti	ructions.)	T	3	1 4					
17	Use Alloc. From S	Stay Care	Model Year and Make	M	onthly Lease Payment	Rental Expense for this Period	17		ere is an option to e provide comple		
18	Anoc. From S	nay Care		Ф		2,707	18	sched		ic uctans on at	iaciicu
19 20							19 20	** This	amount plus any		flooro

21 TOTAL

SEE ACCOUNTANTS' COMPILATION REPORT

2,909

21

expense must agree with page 4, line 34.

						Page 15					
	ne & ID Number Hickory Nursing Pavil				#	0032029	Report Peri	od Beginning:	01/01/04	Ending:	12/31/04
XIII. EXPE	NSES RELATING TO NURSE AIDE TRAINING I	PROGRAMS (See ir	nstructions.)								
							_				
A. TYI	PE OF TRAINING PROGRAM (If aides are trained	d in another facility	program, attach a	schedule listing t	the facility	name, addre	ss and cost per	aide trained in th	nat facility.)		
1	. HAVE YOU TRAINED AIDES	YES 2	. CLASSROOM	PORTION:			3.	CLINICAL PO	RTION:		
	DURING THIS REPORT									_	
	PERIOD?	X NO	IN-HOUSE PR	ROGRAM				IN-HOUSE PR	OGRAM		
			IN OTHER FA	CILITY				IN OTHER FA	CILITY		
	If "yes", please complete the remainder										
	of this schedule. If "no", provide an		COMMUNITY	COLLEGE				HOURS PER A	AIDE		
	explanation as to why this training was		*******								
	not necessary.		HOURS PER A	AIDE							
D EVI	DENICEC						C CO	NITO A CITUAL IN	ICOME		
B, EAI	PENSES	ALLOCATI	ON OF COSTS	(4)			C. CO.	NTRACTUAL IN	NCOME		
		ALLUCATI	ON OF COSTS	(d)				In the box below	w record the	mount of i	naoma vaur
		1	2	3		4		facility received			
		Fa	cility	<u>J</u>		<b>-</b>	$\neg$	racinty received	i ti aining aid	s irom our	er racinties.
		Drop-outs	Completed	Contract		Total		S			
1 (	Community College Tuition	\$	\$	\$	\$			4		_	
	ooks and Supplies	7		7			D. NU	MBER OF AIDE	S TRAINED		
	Classroom Wages (a)										
4 (	Clinical Wages (b)							COMPLET	TED		
5 II	1-House Trainer Wages (c)							1. From this fac	cility		
	ransportation							2. From other f	acilities (f)		
	ontractual Payments							DROP-OU'	TS		
8 N	urse Aide Competency Tests							1. From this fac	cility		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

TOTALS

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

2. From other facilities (f)

TOTAL TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

01/01/04 Ending: 12/31/04

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	v. 51 ECHIL SERVICES (Birett Cost) (	1	2	3	4	5	6	7	8	
		Schedule V	Staff	•	Outsio	le Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other t	(other than consultant)		Total Units	<b>Total Cost</b>	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 39,440	\$		\$ 39,440	1
	Licensed Speech and Language									
2	Development Therapist	39 - 03	hrs			880			880	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			44,294			44,294	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39 - 02	prescrpts				36,019		36,019	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
									·	
14	TOTAL			\$		\$ 84,614	\$ 36,019		\$ 120,633	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached.

		$\begin{vmatrix} 1 \\ 0 \end{vmatrix}$	perating	(		
	A. Current Assets					
1	Cash on Hand and in Banks	\$	277,922	\$	313,883	1
2	Cash-Patient Deposits		27,298		27,298	2
	Accounts & Short-Term Notes Receivable-					
3	Patients (less allowance )		563,725		563,725	3
4	Supply Inventory (priced at )					4
5	Short-Term Investments					5
6	Prepaid Insurance		67,084		67,084	6
7	Other Prepaid Expenses					7
8	Accounts Receivable (owners or related parties)				14,039	8
9	Other(specify): See Attached Schedule					9
	TOTAL Current Assets					
10	(sum of lines 1 thru 9)	\$	936,029	\$	986,029	10
	B. Long-Term Assets					
11	Long-Term Notes Receivable					11
12	Long-Term Investments					12
13	Land				74,000	13
14	Buildings, at Historical Cost				1,115,000	14
15	Leasehold Improvements, at Historical Cost		481,249		481,249	15
16	Equipment, at Historical Cost		197,176		308,176	16
17	Accumulated Depreciation (book methods)		(335,268)		(946,261)	17
18	Deferred Charges				12,745	18
19	Organization & Pre-Operating Costs					19
	Accumulated Amortization -					
20	Organization & Pre-Operating Costs				(7,650)	20
21	Restricted Funds					21
22	Other Long-Term Assets (specify):					22
23	Other(specify): See Attached Schedule					23
	TOTAL Long-Term Assets					
24	(sum of lines 11 thru 23)	\$	343,157	\$	1,037,259	24
	TOTAL ASSETS					
25	(sum of lines 10 and 24)	\$	1,279,186	\$	2,023,288	25

		1 O	perating		2 After onsolidation*	
	C. Current Liabilities					
26	Accounts Payable	\$	60,226	\$	60,225	26
27	Officer's Accounts Payable					27
28	Accounts Payable-Patient Deposits		27,298		27,298	28
29	Short-Term Notes Payable		56,794		56,794	29
30	Accrued Salaries Payable		36,095		36,095	30
	Accrued Taxes Payable					
31	(excluding real estate taxes)					31
32	Accrued Real Estate Taxes(Sch.IX-B)		94,705		94,705	32
33	Accrued Interest Payable					33
34	Deferred Compensation					34
35	Federal and State Income Taxes					35
	Other Current Liabilities(specify):					
36	See Attached Schedule		287,262		75,584	36
37			ĺ		ĺ	37
	TOTAL Current Liabilities					
38	(sum of lines 26 thru 37)	\$	562,380	\$	350,701	38
	D. Long-Term Liabilities					
39	Long-Term Notes Payable				550,212	39
40	Mortgage Payable					40
41	Bonds Payable					41
42	Deferred Compensation					42
	Other Long-Term Liabilities(specify):					
43	See Attached Schedule					43
44						44
	TOTAL Long-Term Liabilities					
45	(sum of lines 39 thru 44)	\$		\$	550,212	45
	TOTAL LIABILITIES					
46	(sum of lines 38 and 45)	\$	562,380	\$	900,913	46
47	TOTAL EQUITY(page 18, line 24)	\$	716,806	\$	1,122,375	47
	TOTAL LIABILITIES AND EQUITY		710,000	Ψ	1,122,073	
48	(sum of lines 46 and 47)	\$	1,279,186	\$	2,023,288	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

1 Total 1 Balance at Beginning of Year, as Previously Reported 819,992 1 2 Restatements (describe): 2 3 3 4 4 5 6 Balance at Beginning of Year, as Restated (sum of lines 1-5) 819,992 6 A. Additions (deductions): 7 NET Income (Loss) (from page 19, line 43) 44,814 7 8 Aquisitions of Pooled Companies 8 9 Proceeds from Sale of Stock 9 10 Stock Options Exercised 10 11 Contributions and Grants 11 12 Expenditures for Specific Purposes 12 13 Dividends Paid or Other Distributions to Owners (148,000)13 14 Donated Property, Plant, and Equipment 14 15 Other (describe) 15 16 Other (describe) 16 17 17 TOTAL Additions (deductions) (sum of lines 7-16) (103,186)B. Transfers (Itemize): 18 18 19 19 20 20 21 21 22 22 23 TOTAL Transfers (sum of lines 18-22) 23 24 BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) 24 716,806

<sup>\*</sup> This must agree with page 17, line 47.

# 0032029 **Report Period Beginning:** 01/01/04 XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue		Amount	
	A. Inpatient Care		Amount	
1	Gross Revenue All Levels of Care	S	2,352,903	1
2	Discounts and Allowances for all Levels	Ψ	(223,481)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	S	2,129,422	3
	B. Ancillary Revenue		2,12>,122	_
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy		226,572	6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	226,572	8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs		52,797	17
18	Sale of Supplies to Non-Patients			18
19	Laboratory		4,099	19
20	Radiology and X-Ray		1,605	20
21	Other Medical Services		6,389	21
	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	64,890	23
	D. Non-Operating Revenue			
24	Contributions			24
25	Interest and Other Investment Income***		2,378	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	2,378	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28	See Supplemental Schedule			28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	2,423,262	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		508,510	31
32	Health Care		810,905	32
33	General Administration		594,819	33
	B. Capital Expense			
34	Ownership		302,955	34
	C. Ancillary Expense			
35	Special Cost Centers		120,633	35
36	Provider Participation Fee		40,626	36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	2,378,448	40
44	Y 10 Y 7 (1 20 1 W 10)		44.04.4	
41	Income before Income Taxes (line 30 minus line 40)**		44,814	41
42	I T			42
42	Income Taxes	<u> </u>		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	44,814	43

- This must agree with page 4, line 45, column 4.
- Does this agree with taxable income (loss) per Federal Income Cash Basis If not, please attach a reconciliation. Tax Return?
- \*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT
- \*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

		1	2**	3	4					
		# of Hrs.	# of Hrs.	Reporting Period	Avera	age				Nu
		Actually	Paid and	Total Salaries,	Hou	rly				of
		Worked	Accrued	Wages	Was	ge				Pa
1	Director of Nursing	1,872	2,019	\$ 66,429	\$ 32.	90 1	1			Ac
2	Assistant Director of Nursing					2	3	5	Dietary Consultant	Mor
3	Registered Nurses	1,403	1,418	33,906	23.	91 3	3	6	Medical Director	Mor
4	Licensed Practical Nurses	13,021	14,136	280,311	19.	83 4	3	7	Medical Records Consultant	Mon
5	Nurse Aides & Orderlies	22,836	24,625	227,287	9.	23 5	3	8	Nurse Consultant	
6	Nurse Aide Trainees					6	3	9	Pharmacist Consultant	Mor
7	Licensed Therapist					7	4	0	Physical Therapy Consultant	
8	Rehab/Therapy Aides	1,561	1,704	17,365	10.	19 8	4	1	Occupational Therapy Consultant	
9	Activity Director	1,927	1,997	19,752	9.	89 9	4	2	Respiratory Therapy Consultant	
10	Activity Assistants	2,917	3,222	23,454	7.	28 10	4	3	Speech Therapy Consultant	
11	Social Service Workers	5,401	5,401	67,515	12.	50 11	4	4	Activity Consultant	
12	Dietician	ĺ				12	4	5	Social Service Consultant	
13	Food Service Supervisor	1,919	2,105	28,883	13.	72 13	4	6	Other(specify)	
14	Head Cook	ŕ	, and the second second	,		14	4	7		
15	Cook Helpers/Assistants	9,292	10,034	79,272	7.	90 15	4	8		
	Dishwashers	,	ĺ	,		16				
17	Maintenance Workers	2,066	2,299	24,918	10.	84 17	4	9	TOTAL (lines 35 - 48)	
18	Housekeepers	10,034	10,545	75,502	7.	16 18			,	
19	Laundry	3,376	3,691	31,266	8.	47 19				
20	Administrator	2,012	2,109	55,762	26.	44 20				
21	Assistant Administrator	ŕ	, and the second	,		21	C.	. C	ONTRACT NURSES	
22	Other Administrative					22				
23	Office Manager					23				Nu
24	Clerical	1,180	1,240	23,621	19.	05 24				of
25	Vocational Instruction	,	ŕ	,		25				Pa
26	Academic Instruction					26				Ac
27	Medical Director					27	5	0	Registered Nurses	
28	Qualified MR Prof. (QMRP)					28	5	1	Licensed Practical Nurses	
	Resident Services Coordinator					29	5	2	Nurse Aides	
30	Habilitation Aides (DD Homes)					30				
	Medical Records	2,464	2,753	38,325	13.	92 31	5	3	TOTAL (lines 50 - 52)	
	Other Health Care(specify)	, -	,	/-		32			, , , , , ,	
33	Other(specify) See Supplemental					33				
34	TOTAL (lines 1 - 33)	83,281	89,299	s 1,093,568 *	s 12.	25 34	SEE AC	CC	OUNTANTS' COMPILATION REP	ORT

## B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	Monthly	\$ 5,904	01-03	35
36	Medical Director	Monthly	5,500	09-03	36
37	Medical Records Consultant	Monthly	2,112	10-03	37
38	Nurse Consultant	6	200	10-03	38
39	Pharmacist Consultant	Monthly	1,190	10-03	39
40	Physical Therapy Consultant	14	698	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,533	11-03	44
45	Social Service Consultant	47	2,418	12-03	45
46	Other(specify)				46
47					47
48					48
_					
49	TOTAL (lines 35 - 48)	97	s 19,555		49

## C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

<sup>\*\*</sup> See instructions.

# 0032029 Ending: Facility Name & ID Number **Hickory Nursing Pavilion Report Period Beginning:** 01/01/04 12/31/04 XIX. SUPPORT SCHEDULES A. Administrative Salaries Ownership D. Employee Benefits and Payroll Taxes F. Dues, Fees, Subscriptions and Promotions Description Description Name Function % Amount Amount Amount IDPH License Fee Meridee Lynn Watt Administrator 55,762 Workers' Compensation Insurance 18,773 **Unemployment Compensation Insurance** 22,009 Advertising: Employee Recruitment 2,501 FICA Taxes Health Care Worker Background Check 78,980 **Employee Health Insurance** 46,123 (Indicate # of checks performed 420 Employee Meals 66,795 Licenses, Permits & Fees 1,234 Illinois Municipal Retirement Fund (IMRF)\* Advertising & Promotion 6,845 520 **Dues & Subscribtions Employee Benefits** 2,762 TOTAL (agree to Schedule V, line 17, col. 1) Union Pension Expense 8,150 Yellow Page Advertising 3,448 (List each licensed administrator separately.) 55,762 401K Employeer 297 B. Administrative - Other Holiday Expense 1,194 Less: Public Relations Expense Description Non-allowable advertising (6.845)Amount **Management Fees - Stay Care** 146,400 Yellow page advertising (3,448)TOTAL (agree to Schedule V, TOTAL (agree to Sch. V, 6,917 242,841 line 22, col.8) line 20, col. 8) TOTAL (agree to Schedule V, line 17, col. 3) 146,400 E. Schedule of Non-Cash Compensation Paid G. Schedule of Travel and Seminar\*\* (Attach a copy of any management service agreement) to Owners or Employees C. Professional Services Description Amount Vendor/Pavee Description Line# Type Amount Amount Accounting Frost, Ruttenberg & Rothblatt 18,756 Out-of-State Travel Personel Planners **Unemployment Consultant** 880 Querry & Harron 20,000 Legal Sachnoff & Weaver Legal 6,195 In-State Travel MDI Technologies **Computer Services** 6,912 Seminar Expense 2,360 Alloc. From Stay Care 255

> \* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

TOTAL

52,743

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$2500 attach copy of invoices.)

TOTAL line 24, col. 8)

\*\*See instructions.

**Entertainment Expense** 

(agree to Sch. V,

2,615

Page 21

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													<u> </u>
17													
18								1	1			<u> </u>	1
19													1
	TOTALG						0	0	0				
20	TOTALS		15		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facilit	y Name & ID Number Hickory Nursing Pavilion	STATE (	OF ILLINOIS 0032029	Report Period Beginning:	01/01/04	Ending:	Page 23 12/31/04
	ENERAL INFORMATION:		0002029	report renou segiming.	01/01/01	Z. Carring.	12/01/01
	Are nursing employees (RN,LPN,NA) represented by a union?  Yes	(13)		supplies and services which are of the Public Aid, in addition to the daily r			
(2)	Are there any dues to nursing home associations included on the cost report?  If YES, give association name and amount.  ICLTC \$4,440.00	4.6	in the Ancillary Se	ection of Schedule V? Yes	_		0
(3)	Did the nursing home make political contributions or payments to a political action organization?  Yes  If YES, have these costs been properly adjusted out of the cost report?  Yes	(14)	the patient census is a portion of the	building used for any function other listed on page 2, Section B? No building used for rental, a pharmacy, explains how all related costs were a	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  No If YES, what is the capacity?	(15)	Indicate the cost of on Schedule V. related costs?		ssified to emply meal income the amount.	been offset ag	
(5)	Have you properly capitalized all major repairs and equipment purchases?  What was the average life used for new equipment added during this period?  Yes  10 Years	(16)	Travel and Transpo	ortation	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,057 Line 10		If YES, attach a	complete explanation. eparate contract with the Departmen	t to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  Yes  If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ N/A fall travel expense relates to transporting age logs been maintained? N/A			
(8)	Are you presently operating under a sale and leaseback arrangement?  If YES, give effective date of lease.  No  No		e. Are all vehicles times when not	stored at the nursing home during th	•		
(9)	Are you presently operating under a sublease agreement? YES X NO	)	out of the cost re	eport? Yes ity transport residents to and fr			
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.	,	Indicate the a	mount of income earned from p n during this reporting period.	providing suc		
		(17)	Firm Name:	performed by an independent certific	•	The instruct	
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 40,626  This amount is to be recorded on line 42 of Schedule V.		cost report require been attached?	that a copy of this audit be included  If no, please explain.	with the cost r	eport. Has thi	s copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  No If YES, attach an explanation of the allocation.		out of Schedule V			-	
	SEE ACCOUNTANTS' COMPILATION REPORT	(19)	performed been att	re in excess of \$2500, have legal invalued to this cost report? Yes d a summary of services for all architecture.		-	ices